

**DISTRICT OF COLUMBIA**  
**OFFICE OF ADMINISTRATIVE HEARINGS**  
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E.N.

Petitioner

v.

SUPERIOR SERVICE GROUP HOMES  
Respondent

Case No.: 2011-DMH-00005

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**FINAL ORDER**

**I. Introduction**

In this case, the Petitioner, E.N., challenges a discharge notice issued to her by Superior Service Group Homes (“Superior”). Superior wants to discharge Ms. E.N. from a mental health community residence facility (“CRF”) that it operates. I have concluded that the applicable law - Title III of the Nursing Home and Community Residence Facility Residents' Protections Act of 1985, D.C. Official Code § 44-1003.01 *et seq.* (the “Act”) – does not allow Superior to discharge Ms. E.N. Therefore, the notice of discharge will be reversed.

**II. Procedural Background**

Counsel for Ms. E.N. filed a hearing request on July 20, 2011, seeking to challenge a discharge notice issued to Ms. E.N. and dated July 14, 2011. The Act requires a prompt hearing and decision in such cases. D.C. Official Code § 44-1003.03(b) (hearing in 5 calendar days;

decision in 7 calendar days after hearing request is received). For that reason I set a status conference for July 22, 2011 in order to set a hearing date and deal with other procedural issues.

The parties asked for a continuance, and I held the status conference on July 28, 2011. As the result of that conference, Superior issued a new, superseding discharge notice to Ms. E.N. that same day. I ordered that her original hearing request was deemed to be a challenge to that discharge notice, and the discharge was stayed pursuant to D.C. Official Code § 44-1003.03(a). The parties agreed to a hearing date of August 17, 2011.

The parties requested two continuances of that hearing date, and the hearing was eventually scheduled for the morning of August 30, 2011. The hearing did not take place that morning, for two reasons. First, one of Superior's witnesses, Ms. Goodring, became ill in the hearing room immediately before the hearing and was transported to the hospital by paramedics. Second, Ms. E.N. was not present, although her attorney, Mary Ann Parker, Esq., of the Office of the Long-Term Care Ombudsman, was present. Several participants in the hearing reported that Ms. E.N. adamantly refused to attend the hearing.

To ensure that Ms. E.N. understood the nature of the proceedings and the risk of not attending the hearing, I contacted her by telephone at the Superior CRF and spoke with her on the record with all parties present. I made several attempts to explain to Ms. E.N. why a hearing was occurring, but Ms. E.N. continually (and angrily) interrupted both me and others who tried to speak with her. She eventually hung up, and I recessed the hearing until 3:00 PM. To guarantee that there was effective notice to Ms. E.N., I issued an order explaining the nature of the hearing and its possible consequences, and ordered it to be served by hand on Ms. E.N.

The hearing reconvened at 3:00 PM, and Ms. Parker confirmed that she gave the order to Ms. E.N. and reviewed it with her. Ms. E.N. elected not to attend the hearing. Because Superior has the burden of proof in this matter, and because Ms. E.N.'s counsel was present and ready to proceed, I did not dismiss the case for Ms. E.N.'s non-attendance. Instead, the hearing went forward with testimony from witnesses for both parties. Delores Flowers, Superior's owner, and Leslie DeVeau, the inspector from the Department of Mental Health ("DMH") assigned to that facility, testified for Superior. Lydia Williams from the Long-Term Care Ombudsman's office testified for Petitioner.<sup>1</sup>

Ms. Goodring, the witness who became ill, was the Superior staff member who had the most contact with Ms. E.N. During the morning session, I explained to Ms. Flowers that she could have a continuance of the hearing in light of Ms. Goodring's illness. Ms. Flowers elected to proceed with the hearing and to present mainly hearsay testimony about Ms. Goodring's observations.

Based on the testimony of the witnesses, my evaluation of their credibility and the exhibits admitted into evidence, I now make the following findings of fact and conclusions of law.

### **III. Findings of Fact**

#### **A. Preliminary Consideration – The Standard of Proof**

A CRF seeking to discharge a resident must prove the existence of one or more of the grounds specified in the Act, and must do so by clear and convincing evidence. D.C. Official

Code § 44-1003.03 (b) and (c). This is a higher standard of proof than preponderance of the evidence. It requires proof that creates “a firm belief or conviction as to the facts sought to be established.” *In re K.D.*, 2011 D.C. App. LEXIS 508 at \*12 (D.C. August 25, 2011) (citation and internal quotes omitted). I have evaluated the evidence according to that standard, and the findings of fact below have been established by clear and convincing evidence.

### **B. The Discharge Notice**

Ms. E.N. has resided at the CRF for about 13 years. Recently, Ms. E.N.’s behavior has changed and, as a result, Ms. Flowers believes it is necessary to discharge her from the facility. Superior issued a discharge notice to Ms. E.N. on July 28, 2011. Respondent’s Exhibit (“RX”) 203. That notice identifies the following reasons for the discharge:

Disobeys house rules

Smokes in room, burns candles in room

[P]lays loud music and disruptive to adjoining neighbors and other consumers in the house

Don’t [*sic*] take medication

RX 203 is a form prepared by DMH for use when a mental health CRF seeks to discharge a resident. The section that says, “You will be . . . discharged/transferred to the following address,” is blank. Nothing in the notice tells Ms. E.N. where Superior is proposing to send her, and Superior has provided no evidence that it has identified any such place.

Ms. E.N. is not necessarily opposed to moving out of the CRF. She would like to get her own apartment, but has not yet located one. It is uncertain when, or if, she will succeed in securing an apartment.

### C. Smoking

Based on her review of notes kept by Ms. Goodring and others, Ms. Flowers testified that Ms. E.N. was smoking in her room on the following days: July 22, and 27, and August 4, 6, 8, 13, 19, 20 and 21. There is no evidence of any smoking after August 21.<sup>2</sup>

Ms. Flowers had no personal knowledge of Ms. E.N.'s smoking. The source of her testimony was a notebook in which the staff began to record incidents of Ms. E.N.'s smoking. It appears that the effort to record this information began in mid-July, after issuance of the original discharge notice on July 14. The notebook itself is not in evidence, but it was available to counsel for Ms. E.N. In addition, Petitioner's witness Lydia Williams reviewed the notebook on the day before the hearing.

The notebook is not a systematic, detailed record, but rather a series of disjointed notes made at different times. It is far from clear that the entries in the notebook were made at or near the time of the events they describe. For example, Ms. Flowers' testimony that Ms. E.N. was smoking on August 19, 20 and 21 was based upon a loose sheet of paper inserted into the notebook. RX 204. That paper contains the following notes:

8/19[or possibly 8/17] [E.N.] was somkes [*sic*] in her room.

8-20-011

8-21[-]011 [E.N.] was somkes [*sic*] in her room [again;] she just won't stop[.] She need [*sic*] to be in a C.P.

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<sup>2</sup> Ms. Flowers contended that Ms. E.N. has been using bleach in her room to mask the smell of smoke, which creates the possibility that she has been smoking at other times. Ms. Flowers gave no details about when, or how often, Ms. E.N. used the bleach and there is no basis for concluding that any use of bleach demonstrates that Ms. E.N. was smoking on any other dates.

RX 204 was not in the notebook when Ms. Lydia Williams reviewed it on the day before the hearing. Instead, it was inserted there by another worker after Ms. Flowers realized that the other worker's observations were not there. The joint entry for August 20 and 21 makes it apparent that these are not contemporaneous records of what occurred, and RX 204 contains few details about the alleged incidents, such as their time, the circumstances under which Ms. E.N. was discovered, or any conversation with Ms. E.N. Indeed, it is not even clear whether the author of those notes observed Ms. E.N. or whether she wrote what someone else told her. For all these reasons, I find that the hearsay record of RX 204 does not provide clear and convincing evidence that Ms. E.N. was smoking in her room on the dates reflected in that exhibit.<sup>3</sup>

The notebook contains several other entries recorded by Ms. Goodring that mention smoking by Ms. E.N. on July 22, and 27, and August 4, 6, 8 and 13. There is less dispute about Ms. E.N.'s smoking earlier in August, although the exact dates of all the incidents may be uncertain. The lack of any evidence about how the entries were prepared, the level of detail they contain, and the source of the information all make it impossible to find, by clear and convincing evidence, that Ms. E.N. was smoking on those specific dates. Nevertheless, it is undisputed that Ms. E.N. was smoking in her room on more than one occasion in late July and early August. The notebook actually contains a letter from Ms. E.N. to her attorney, Ms. Parker, admitting that she smoked in her room on August 6 because her leg hurt and she didn't want to walk down

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<sup>3</sup> I recognize that the issue before me is not whether the facility kept good records. The specific issue here is whether there is clear and convincing evidence that Ms. E.N. was smoking in her room on the days reflected in RX 204. The records are the only evidence in support of that allegation, however, and in light of the demanding standard of proof, I can not credit them.

from the third floor to smoke outside.<sup>4</sup> The evidence, however, does not establish any smoking incidents for at least three weeks before the hearing.

#### **D. Candles**

The evidence shows only one incident involving a burning candle, which occurred in July. Ms. E.N. was burning a candle at about 2:30 AM. The smoke from the candle activated the fire alarm in the house, and all the residents had to be evacuated. The experience was especially traumatic to one resident, who previously had been injured in a fire. He continued to be upset about the incident throughout August.

#### **E. Medication**

Based upon Superior's records, Ms. Flowers testified that Ms. E.N. did not take her medication on the following days: July 23, 25 and 26, and August 7, 8, 12, and 16. According to Ms. Flowers, facility staff would give Ms. E.N. her medication, but she would take the pill and put it in her pocket. Once again, Ms. Flowers relied solely upon the facility's records for her testimony. Here, too, the evidence shows that Superior's recordkeeping practices were poor. As a result, I do not find clear and convincing evidence to support Ms. E.N.'s discharge.

I credit the testimony of Ms. Lydia Williams that she reviewed Ms. E.N.'s medication records for August on the day before the hearing and found that many days had no entries at all. When she pointed this out to Ms. Goodring, Ms. Goodring simply wrote "R" (which stands for "refused") in the columns for those days. Such poor records, unsupported by any other evidence,

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<sup>4</sup> Ms. E.N. wrote the letter in the notebook, a source that was accessible to the CRF's staff. There was no objection that the letter was privileged.

do not provide clear and convincing evidence that Ms. E.N. failed to take her medication on the specific days alleged by Superior.

RX 202 contains a list of Ms. E.N.'s prescribed medications.<sup>5</sup> According to Ms. Flowers, some of them are for diabetes. She gave no information about the others, and no information about which medications Ms. E.N. refused to take. This is an insufficient basis for a finding, by clear and convincing evidence, that any failure by Ms. E.N. to take her medication has affected her behavior or has caused her to be dangerous to herself or others.

#### **F. Loud Music**

On one or two occasions during July, Ms. E.N. played loud music in her room, and put the speakers in her window facing toward the street. The predictable result was disruption in the neighborhood with several neighbors calling the police. There has been no recurrence of that behavior in August.

#### **G. Other Disruptive Behavior**

Ms. E.N.'s behavior deteriorated during late July and throughout August. She has been disrespectful to staff and other residents, often in a loud tone of voice, and the situation became worse as the month passed. On at least one occasion, police officers came to the CRF in response to complaints about Ms. E.N.'s behavior. They originally planned to remove her for a psychiatric evaluation, but changed their minds after Ms. E.N. agreed to take her medication, and an officer witnessed her doing so.

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<sup>5</sup> RX 202 is a record of the administration of medications for July 2011. Although it was offered simply to show the list of prescribed medications for Ms. E.N., it supports the finding of inadequate recordkeeping concerning Ms. E.N.'s medications. There are no entries at all for 14 days during July.



Other than testimony that Ms. E.N. has been disrespectful, there is no evidence of specific rules violations and no evidence that her disrespectful behavior has created a danger to herself or others.

#### **IV. Conclusions of Law**

All parties agree that Superior's CRF is subject to the discharge provisions of Title III of the Nursing Home and Community Residence Facility Residents' Protections Act of 1985, D.C. Official Code § 44-1003.01 *et seq.* In that Act, the Council specified both procedural requirements that must be followed and substantive rights that must be respected whenever a CRF seeks to discharge a resident without that resident's consent. The evidence in this case shows that the proposed discharge of Ms. E.N. does not satisfy standards enacted by the Council, for two principal reasons.

##### **A. The Notice**

Before a resident is discharged involuntarily, the law requires the facility to provide a detailed written notice to the resident, the resident's representative and others. D.C. Official Code § 44-1003.02. All discharge notices must contain, among other information, "[t]he location to which the resident will be transferred." D.C. Official Code § 44-1003.02(d)(7). The notice issued to Ms. E.N. contains no such information. Residents of nursing homes and CRFs are a particularly vulnerable population. They reside in those facilities precisely because they can not care for themselves and need, to a greater or lesser extent, assistance with their daily activities, as well as care for their physical and mental health. The apparent purpose of subsection (d)(7) is to require the provider operating a facility to plan adequately for a discharge so that the future needs of the resident will be met. The Act does not authorize a CRF simply to

expel a resident without a plan for where the resident will go.<sup>6</sup> Because Superior did not identify a location where Ms. E.N. would go, the discharge notice does not comply with the law, and Superior may not discharge Ms. E.N. based on that notice.

### **B. The Emergency Discharge Provision**

Superior also did not prove that there was a permissible reason for the discharge. The Act allows a CRF to discharge a resident only for one of the following reasons:

- (1) If essential to meet that resident's documented health-care needs or to be in accordance with his or her prescribed level of care;
- (2) If essential to safeguard that resident or one or more other residents from physical or emotional injury;
- (3) On account of nonpayment for his or her maintenance, after reasonable and appropriate notice, . . . ;
- (4) If essential to meet the facility's reasonable administrative needs and no practicable alternative is available; or
- (5) If the facility is closing or officially reducing its licensed capacity.

D.C. Official Code § 44-1003.01(a).

Superior relied exclusively on the ground specified in subsection (2), arguing that the discharge is essential to safeguard Ms. E.N. and the other residents from the dangers caused by her smoking and her burning of candles. In Superior's opinion, Ms. E.N.'s actions present a serious fire hazard and therefore a threat of physical injury.

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<sup>6</sup> Notably, the discharge provisions of the Homeless Services Reform Act, D.C. Official Code §§ 4-754.33(d) and 4-754.36 do not contain a similar requirement. While there are various substantive and procedural requirements before a client is discharged from a homeless shelter, the Council did not require a shelter to designate another place for the client to live. The greater obligation imposed upon nursing homes and CRFs reflects the greater needs of the population likely to reside in those facilities.

Initially, I must determine the time frame within which I should review Ms. E.N.'s actions. The discharge notice, RX 203, was signed on July 28, 2011, and it necessarily refers to actions that occurred on or before that date. The evidence at the hearing, however, concerned mostly events occurring after that date. Because both parties presented evidence that post-dates the discharge notice, I conclude that my task is to evaluate the situation as of the date of the hearing.<sup>7</sup> In other words, I must assess whether Ms. E.N. now presents a danger to herself or other residents of the facility. In doing so, I must evaluate the behavior that has been established by the evidence and must decide whether that behavior demonstrates that she now presents a danger to herself or others.

Superior's primarily relies upon the evidence of Ms. E.N.'s smoking and burning of candles. It argues that her discharge is essential to avoid the fire hazards that her behavior creates. The last smoking incident established by the evidence occurred more than three weeks before the hearing, and the only candle incident occurred more than a month before the hearing. Judged by the demanding "clear and convincing" standard, this evidence does not persuade me that Ms. E.N. will continue to smoke or burn candles in her room. So far as the evidence shows, her smoking and burning candles in her room were confined to a period of a few weeks and has not recurred. To be sure, I heard no testimony from Ms. E.N. explaining why her behavior in this regard has changed, and I recognize the possibility that she can begin that dangerous behavior again. But suggesting a possibility is not the same as establishing a "firm belief or conviction" that the behavior will recur. The evidence here does not meet that strict standard.

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<sup>7</sup> In effect the parties' presentations asked me to decide whether Ms. E.N.'s discharge is, at present, essential to safeguard her or another resident from injury. That issue was tried by consent of the parties, and I may decide it. D.C. Superior Court – Civil Rule 15(b) (applicable pursuant to OAH Rule 2801.1, 1 DCMR 2801.1).

Evidence of the other behaviors is also insufficient. Ms. E.N.'s playing of loud music was certainly annoying, but it is not evidence of any danger to herself and others. General testimony that she has been disobeying house rules does not show that she is dangerous, absent evidence of the specific rules she disobeyed and the nature of any danger presented by those rule violations.<sup>8</sup> Because I have found the evidence insufficient to establish either the extent to which Ms. E.N. has refused any medications, or how any failure to take medication would lead to dangerous behavior, the evidence concerning medications is also insufficient to support her discharge.

In summary, Ms. E.N.'s smoking and candle-burning during a few weeks in late July and early August presented a fire hazard in the CRF, but that hazard has not occurred during at least the past three weeks. Ms. E.N.'s behavior has been unacceptable in other respects, but unacceptable behavior is not the same as dangerous behavior, and there is nothing about her current unacceptable behavior that creates a firm belief or conviction that dangerous behavior is going to follow.

I emphasize that, when there is a clear, current risk that a resident will be dangerous to herself or others in the facility, a CRF does not have to wait for harm to occur before initiating a discharge. But in this case, whatever risk was presented by Ms. E.N. has diminished to the point that there is presently not clear and convincing evidence that her discharge is essential to

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<sup>8</sup> Here, too, comparison with the discharge provisions of the Homeless Services Reform Act is useful. The HSRA expressly permits shelters to discharge residents for repeated rules violations, without any consideration of whether such behavior endangers anyone. D.C. Official Code § 4-754.36(2)(G). There is no such authority to discharge CRF residents.

safeguard her or other residents.<sup>9</sup> I am persuaded that Ms. E.N. recently has become a difficult resident, but the Act does not permit the discharge of residents because they are difficult.<sup>10</sup> Absent clear and convincing evidence that she presents a current danger to herself or others, Superior may not discharge Ms. E.N.

### **C. Summary**

For two reasons, the proposed discharge of Ms. E.N. does not comply with the standards established by the Council. The discharge notice did not identify the location to which Ms. E.N. would be sent, and Superior did not prove, by clear and convincing evidence, that the discharge of Ms. E.N. is essential to safeguard her or other residents.

### **V. Order**

Based on the findings of fact and conclusions of law, it is, this \_\_\_\_\_ day of \_\_\_\_\_, 2011:

**ORDERED**, that the discharge notice issued to Ms. E.N. is **REVERSED**. Superior may not discharge Ms. E.N. based on that notice; and it is further

**ORDERED**, nothing in this Order prevents the issuance of a new discharge or transfer notice to Ms. E.N. by Superior or by DMH if circumstances warrant; and it is further

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<sup>9</sup> It must be noted that, in the face of claims that Ms. E.N.'s discharge was essential to safeguard herself and the other residents, Superior was willing to postpone the hearing in this case for more than a month.

<sup>10</sup> In her testimony, Ms. DeVeau referred to 22 DCMR 3827.1, which states that a mental health CRF "shall admit and retain only those persons for whom it can care for safely and adequately . . . ." Nothing in that regulation changes the standards for a discharge under D.C. Official Code § 44-1003.01(a)(2), which requires clear and convincing evidence that the discharge is essential to safeguard the resident or other residents of the CRF.

**ORDERED**, that any party may ask for reconsideration or relief from this Order as stated below; and it is further

**ORDERED**, that any party may appeal this Order by following the instructions below.

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John P. Dean  
Principal Administrative Law Judge